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STATEMENT BY

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Chairman Nelson, Senator Graham and distinguished members of the personnel subcommittee: thank you for the opportunity to discuss the Army's efforts in improving the mental healthcare for our Soldiers and their Family members. We are committed to getting this right and providing a level of care and support to our Warriors and Families that is equal to the quality of their service. Secretary Geren, General Casey, General Cody, and the rest of the Army leadership actively support our efforts in improving the access to and quality of mental healthcare services. They are also actively engaged in changing the culture and eliminating the stigma associated with seeking Mental Healthcare that not only our Army, but our Nation, experiences.

We all recognize that the increased operational demand of our military force to fight the global war on terror has stressed our Army and our Families. The DoD and the Army have made a concerted effort to proactively research the effects of this conflict through the DOD's Mental Health Task Force as well as the Mental Health Advisory Team's annual assessments. We know from this research that repeated and extended deployments have led to increased distress, family difficulties, and other psychological effects of war, such as symptoms of post-traumatic stress as well as post-traumatic stress disorder (PTSD). The Army is absolutely committed to ensuring all Soldiers and their Families are healthy, both physically and psychologically. We have made a concerted effort to mitigate risks and enhance mental healthcare services through various programs and initiatives which directly align with the DoD's Mental Health Task Force Report's 4 major recommendations: 1) Build a culture of support for psychological health; 2) Ensure a full continuum of excellent care for service members and their families; 3) Provide sufficient resources and allocate them according to requirements; 4) Empower leadership.

Enhancing, protecting, and improving the mental health for our Soldiers and Families starts from the time a Soldier enters the Army, through various stages of their service, which includes getting ready for deployment, being deployed, and returning from deployment (often referred to as the Army Force Generation or ARFORGEN cycle) as well as departure from service.

From the moment they start Basic Combat Training and at every successive assignment, Soldiers and their Families have access to a wide range of support services – the Installation's Army Community Service program, the Chaplain's network, Leadership and Family Readiness Groups, and of course healthcare at either the military facilities on post or the extensive TRICARE network of providers in the civilian community.

During a Soldier's service it is very likely that he or she can be called to deploy to a remote location of the world away from their Families for various and sometimes extensive lengths of time. The Army has wisely recognized that building Soldier and Family resiliency to this stressor is key to maintaining their health and welfare. We developed "Battlemind" products to increase this resiliency and have several different training programs available for pre, during and post-deployment. These programs are designed for Soldiers and their Families, including children as young as pre-school aged to teens, and they are distributed throughout the force. These programs are also available online anytime at www.behavioralhealth.army.mil.

In a parallel effort to both raise awareness and reduce the stigma associated with mental healthcare, the Secretary of the Army and Chief of Staff of the Army initiated a leader chain teaching program to educate all Soldiers and leaders about post-traumatic stress and signs and symptoms of concussive brain injury. This was intended to help us all recognize symptoms and encourage seeking treatment for these conditions. All Soldiers were mandated to receive this training between July and October 2007, during which time we trained over 800,000 Soldiers. We are now institutionalizing this training within our Army education and training systems to continue to share the information with our new Soldiers and Leaders and to continue to emphasize that these signs and symptoms are a normal reaction to a stressful situation and it is absolutely acceptable to seek assistance to cope with these issues.

During deployments, the Army found tremendous value in providing mental health treatment far forward in the operational areas. Our primary method of providing both preventive and required mental health treatment was through Combat Stress Control Teams. From the beginning of combat operations, there has been a robust

Combat Stress Control presence in theater, with approximately 200 deployed behavioral health providers to Iraq alone. These combat stress control assets are heavily utilized to monitor and mitigate the effects of multiple and extended deployments. This is now a joint effort, with the Air Force assisting us in Iraq and Afghanistan and the Navy in Kuwait. The Army has also done unprecedented work in surveillance of Soldiers, both in the combat theater and back home. The Mental Health Advisory Teams (MHATs) have gone to theater every fall since 2003 and surveyed Soldiers, care providers, chaplains and others. Their findings on epidemiology of symptoms, access to care, and stigma, have led to direct and immediate improvements in the way that we deliver care. The fifth MHAT report is due to be released soon.

Upon redeployment, we continue to gather information about physical and psychological health symptoms on the Post-Deployment Health Assessment. Through our use of scientific studies to drive evidence-based practices, such as the work of the Mental Health Advisory Teams, we developed the Post Deployment Health Re-Assessment to screen Soldiers again during a later stage of the reintegration and post-redeployment period. Typically we find the signs and symptoms of post-traumatic stress are not fully apparent until after a 60 – 90 day readjustment period. In addition to these two event driven assessments, we have also implemented an annual screening tool, the Periodic Health Assessment, to further supplement our information.

As expected, through our efforts to reduce stigma, raise awareness, and assess the health, to include mental health, of our Soldiers, the need for behavioral healthcare is increasing. We do have gaps at some locations in meeting behavioral healthcare demand, but we are diligently working on solutions. The Army developed a program titled the Army Family Covenant, which formally commits us to improving access to high quality behavioral health for Soldiers and Families. Through Congressional Supplemental Funding targeted at caring for psychological health, we have been able to focus resources on hiring behavioral health providers. So far, we have been able to hire and put in place 138 providers of about 340 identified requirements in a very competitive hiring environment. We are also pursuing the hire of an additional 40 substance abuse counselors and over 50 marriage and family therapists and have

added about 90 social workers to our Warrior Transition Units. My medical treatment facility commanders tell me that these hires are making a difference. We also have numerous long-term efforts to enhance recruitment and retention of uniformed behavioral health providers.

This committee is familiar with RESPECT-MIL, a program designed to decrease stigma and improve access to care by providing behavioral healthcare in primary care settings. Because of the success of this program, we have initiated further efforts to train primary care providers and integrate behavioral health with primary care. The combination of ongoing education and improved access to care through numerous portals should again help encourage Soldiers to seek care early.

As part of the Army Medical Action Plan (AMAP), we've developed a program for our Warriors in Transition called the Comprehensive Care Plan which is implemented across our 35 Warrior Transition Units (WTU). The continuum of care that a Soldier receives while in the WTU culminates in a care plan which integrates the more conventional medical and surgical interventions we administer to our wounded, ill and Injured Warriors with efforts to optimize the Soldiers' return to uniformed service or transition into successful life as a veteran. These insights were derived from our experiences over the last year and have now been institutionalized under the direction of my Assistant Surgeon General for Warrior Care and Transition, Brigadier General Mike Tucker. Soldiers in the WTUs are expected to be physically, mentally, socially, and spiritually strengthened. They are vocationally enabled and a Life-Care Plan is established for each of them. This program sets the conditions for a successful transition to the VA or society.

As the Army Surgeon General, I am compelled to remain extremely cognizant of the toll that this demand has placed on my health care providers. The Army's uniformed behavioral health providers are among the most highly deployed of any of our specialties. We use numerous recruitment and retention initiatives to encourage them to join and stay in the Army, including increased bonuses for psychologists and increased educational opportunities for social workers. As part of our detailed force management review being led by Major General Gale Pollock, we are assessing our

manpower requirements and will recommend changes to the force structure as needed. We also developed Provider Resiliency Training to mitigate burn-out for not only our medical providers, but also for Army Chaplains and other specialists who are in the business of serving our Soldiers and Families.

Although we have had many successes, there are also areas of concern. These include the increasing suicide rate, accidental deaths due to overdose, and public perceptions that Soldiers are being inappropriately discharged from the Army for personality disorder when in fact they may actually have PTSD or mild TBI.

Unfortunately, active Army suicide rates have increased over the last seven years. Although the Active Army suicide rate is comparable to the demographically-adjusted civilian population rate, it is at an all-time Army high and we are taking action to address it. Over the last two years, there has been a concerted effort to improve suicide prevention. The Army G-1 is leading this effort with support from the medical and chaplain communities. The Army Medical Department's Army Suicide Event Report continues to offer surveillance and perform analysis. Recent analyses of suicides have resulted in concrete recommendations, which are currently being implemented, both in theater and on our installations.

We have also chartered a General Officer Steering Committee to address suicide prevention. We will develop an action plan focused on five areas of emphasis: 1) develop life-coping skills; 2) maintain constant vigilance; 3) encourage help-seeking behaviors and reduce stigma; 4) maintain constant surveillance of behavioral health data, and 5) integrate and synchronize unit and community programs. We must develop actionable intelligence that provides our leaders an analysis of each suicide or attempted suicide that includes lessons learned, trend data, and potential factors to monitor. The intent is to modify leader behavior towards Soldiers who are impacted by stressors and are at risk of harming themselves.

On the issue of accidental overdoses, I recently chartered a multi-disciplinary team of 17 dedicated professionals (psychologists, psychiatrists, physicians, nurses, unit commanders, First Sergeants and Sergeants Major) to analyze and develop risk mitigation strategies to reduce the number of accidental deaths and accidental drug

overdoses within our WTUs. This team recommended 71 risk mitigation strategies to focus on improving identification, training, and monitoring systems. We have already adopted 26 of those recommendations. The Army will improve its capability to identify high-risk soldiers. We will also improve the training of our clinical staff, leaders and Soldiers on risk reduction measures. We have changed policies and procedures to facilitate these risk-reduction measures and we will improve our capability to monitor and track accidental deaths, and accidental drug overdoses.

Finally, there has been a perception that Soldiers are being inappropriately discharged for personality disorder. All Soldiers discharged for personality disorder are required to receive a mental status evaluation as per Army Regulation 635-200. A new policy was implemented in August 2007, requiring a review by the installation's behavioral health chief of all personality disorder discharge recommendations. We are implementing an update to this policy mandating PTSD and mild TBI screenings for any Soldier being discharged for misconduct. This change in policy will mitigate the risk of discharging Soldiers with a health condition that was acquired while serving their country.

I greatly appreciate the privilege to command the United States Army Medical Command and the opportunity to report on the progress we have been making on providing quality mental healthcare to our Soldiers and Families. We appreciate your support as you interact with servicemen and women and their families in your states in communicating our strategic successes in this area. We also appreciate your help in influencing the mental healthcare providers in your areas to accept TRICARE patients which will expand our behavioral healthcare capacity.

In closing, I'd like to share with you a quote from the DoD Mental Health Task Force Report: "In the history of warfare, no other nation or its leadership has invested such an intensive or sophisticated effort across all echelons to support the psychological health of its military service members and families as the Department of Defense has invested during the Global War on Terrorism." Thank you for holding this hearing and giving us the opportunity to share our accomplishments and to reaffirm our unyielding commitment to provide the best care to all our Soldiers and their Families.